

Study Survey : Serosurveillance of *B. Pertussis* among children in Kazakhstan

PART 1

Date of completion (dd/mm/yyyy):

___ / ___ / ___

Recruitment Site - Identification Number:

Participant - Study Identification Number:

QUESTIONS/INSTRUCTIONS

RESPONSES

Demographics

1 Age of the child

___ years

2 Date of Birth: (dd/mm/yyyy)

___ / ___ / ___

3 Sex of the child

☐ Male
☐ Female

4 Is the child registered in a primary school?

☐ Yes
☐ No

Clinical assessment

5 Have your child had periods of prolonged cough during the last 6 months?

☐ Yes
☐ No

6 if yes, what is the cough onset date (dd/mm/yyyy if known, otherwise mm/yyyy)

___ / ___ / ___

7 if yes (to question 5), have your child had any of these symptom?

Whoop
post-tussive vomiting
Cyanosis
Fever

☐
☐
☐
☐

Living condition

8 What are the current living arrangements of your child?

☐ 1. In school dormitory
☐ 2. In apartment/house with family
☐ 3. Other (Explain)

9 How many people share the household with your child?

10 Does your child have any roommates? (i.e. do you share a bedroom with anyone)

☐ Yes
☐ No
☐ NA

11 If yes, how many people share the room?

Life style

12 In the last month, were your child exposed to second-hand smoke indoors?

☐ Yes, every day
☐ Yes, some days
☐ No, not at all

13 In the last 6 months, how often have your child visited and stayed in a crowded place (café, mall, kinder nursery)

☐ Never
☐ Once per week
☐ 2-3 times per week
☐ 4 or more times per week

14 In the last 6 months, have your child traveled abroad?

☐ Yes
☐ No
☐ Unknown

Health characteristics

15 In the past month, have your child taken any antibiotics? (Amoxil, Augmentin, Ciprobay, Zithromax, etc.)

☐ Yes
☐ No
☐ Unknown

16 In the past month, have your child taken any immunosuppressants?
(i.e. systemic cortisone/prednisone, methotrexate, etc.)

☐ Yes
☐ No
☐ Unknown

17 In the past month, have your child had any upper respiratory infections?
(symptoms of cough, runny nose, or sore throat)

- ☐ Yes
☐ No
☐ Unknown

18 Please mark if your child have any of the chronic medical conditions listed?

- ☐ Diabetes
☐ Chronic lung disease*
☐ Autoimmune disease*
☐ Asplenia (no spleen)
☐ Complement deficiency

Vaccination status

19 History of vaccination against pertussis

Date of 1st dose (dd/mm/yyyy): ____ / ____ / ____ Vaccine (brand name): _____

Date of 2nd dose (dd/mm/yyyy): ____ / ____ / ____ Vaccine (brand name): _____

Date of 3rd dose (dd/mm/yyyy): ____ / ____ / ____ Vaccine (brand name): _____

20 Date of any additional dose (dd/mm/yyyy): ____ / ____ / ____ Vaccine (brand name): _____

PART 2: Blood sample and laboratory test

21 blood sample initials:

22 blood sample taken:

- ☐ Yes
☐ No

23 Date of blood specimen collection (dd/mm/yyyy):

Summary of laboratory results

24 Ig G titer (To Pertussis Toxin)

25 Ig A titer (To Pertussis Toxin)

*Chronic lung disease include: asthma, chronic obstructive pulmonary disease

*Autoimmune disease include: Juvenile arthritis, systemic lupus, Celiac disease